

## 1115 Waiver Draft Application Comments – Lore Baker

The 1115 Waiver draft application outlines a variety of ideas that everyone can agree are vital: expansion of Home and Community Based Services (HCBS), expansion of Long Term Supports and Services (LTSS), flexibility, personal choice, linkages, Health Hubs, expanded ACT/CST services, supported employment, non-medical transportation, person-centered care. But from an advocate's perspective, there aren't many details of how these objectives will be achieved. I understand that the application is the starting point for negotiations with CMS but once those negotiations begin, how do we ensure that we are negotiating for the best options? Will there be ongoing opportunity to learn from stakeholders, consumers, providers and experts as the State of Illinois refines the changes that will be approved and implemented? Ongoing roundtables about various best practices for various populations would be beneficial to ensuring that Illinois is crafting the best 1115 Waiver possible.

What follows are questions or suggestions that came to mind as I read the 1115 Waiver draft application:

Pg. 6 How will the State of Illinois support linkages between health care delivery systems and services that directly impact key social determinants of health? Perhaps by requiring specific collaborations through contracting, targeted "matchmaking", hosting regional networking sessions, providing health care entities with lists of state social service provider contractors?

Pg. 7 It will be vitally important to determine how decisions are made about who is eligible for what service. Tiered levels of service can work but we must ensure that flexibility is maintained. In the past, different levels of service have often meant physically moving to different locations in order to receive the level of care or service needed. This has led to Olmstead compliance issues and a heavy reliance on institutions. Services and supports must flex in and out of a person's home.

Pg. 9 How often will the person be assessed and assigned to their appropriate service tier? It is great that non-medical transportation is included in LTSS services! I notice that case management isn't a service listed. Is case management part of the Personal Support, Residential Habilitation or Service Facilitator functions described (particularly for supportive housing)?

Pg. 10 Will HCBS expansion, especially for those with complex health and behavioral health needs, include housing support services?

Pg. 12-17 It seems wise to not include housing production in DSRIP in order to ensure CMS approval. Perhaps CCHHS could pursue developing housing opportunities for the Cook County jail reentry population they are serving with savings or incentive funding?

Pg. 19 What alternative uses could nursing facilities convert to?

Pg. 21 The Regional Public Health Hubs should be required to partner closely with homeless service providers to develop interventions (housing) that can positively affect key social determinants of health like environmental factors. Many of the families and individuals served by public health departments are homeless or at risk of homelessness.

Pg. 25 The idea of adding additional professions, like social workers, to the Health Care Workforce Loan Repayment Program is good and seems to indicate the understanding of the health outcomes value of wrap-around case management.

Pg. 31 The Universal Assessment Tool (UAT) development should take into consideration and integrate other mandated (federal or local) assessment processes. Perhaps the tool could start out with “big bucket” questions that would then target people to the appropriate intervention for further assessment rather than require someone to complete a long questionnaire and then repeat the process with the provider that they are referred to? Maybe it is better to think of it as a screening rather than an assessment? Check out the resources at the National Alliance to End Homelessness website <http://www.endhomelessness.org/library/entry/coordinated-assessment-toolkit>.

Pg. 33 As we develop and implement the Universal Assessment Tool, we should take into consideration people who are already receiving certain sets of supports not currently paid for by Medicaid, for example, supportive housing through the Office of Adult Services and Basic Support targeted to people experiencing homelessness. If those people are assessed to no longer need those supports, how do we assist their moving on, and to where will they move (affordable housing is difficult to access)? If we refer someone to supportive housing, how often will they be reassessed for eligibility for the service? Supportive housing projects must provide proof of ongoing service funding match for the capital and operations funding received from a variety of local, state and federal sources. We need to make sure that we are continually thinking of changing the culture of moving to different locations for different levels of service to service flexing in and around a person, in place in the community, as needed.

Pg. 34 Common service definitions, provider qualifications and reimbursement rates should begin being developed as soon as the 1115 Waiver application is submitted to ensure adequate stakeholder input and a thoughtful process. This will ensure that unforeseen complications will be averted and encourage service provider confidence.

Pg. 35 Thinking about case management or wrap-around supports as part of the Long Term Supports and Services is vital. Are Home and Community Based Service settings any type of housing within the community where a tenant holds a lease and the rights and responsibilities assigned therein? When considering service level tiers, remember that matching service dollars are required by our Federal partners in the various housing programs that they fund.

Pg. 39 The proposed redesign of the behavioral health system is fabulous and should begin as soon as the application is submitted. An emphasis on recovery for all persons and using more peer support services would be incredibly timely and useful for folks transitioning out of institutions through various

consent decrees and facility closures. Illinois should invest in strengthening the voice of consumers and family members in real and meaningful ways.

Pg. 40 Assertive Community Treatment (ACT) teams and Community Support Teams (CST) are wonderful evidence-based practices. We need to explore how our mental health providers have been supporting people moving out of nursing homes for the last thirty years who have no access to ACT or CST resources. When you talk about the most vulnerable and at risk populations, I would include people experiencing homelessness.

Pg. 41 Incentivizing the health care delivery system to invest and build linkages with providers of housing and supportive housing services sounds nice but the vague nature of the plan will concern many providers who have signed 30 year commitments with a variety of funders in order to develop supportive housing resources. The idea of having a committee (or a variety of committees) that will kick-off when the application is submitted to flesh out the details of many of the items within the application will go a long way toward calming the concerns. Current expert providers of a variety of services and supports should be the first to deliver flexible services to populations that are fragile and difficult to find. These providers have worked hard to gain the trust of these vulnerable populations. MCOs and MCCNs will want to develop their own services but we have seen from past experience that they don't necessarily have the skill sets needed, particularly with populations who have not been treated well in hospitals and other healthcare settings. We need to ensure that the experts continue to provide the service to the people that they have relationships with.

Pg. 42 While access to financial resources such as SSI or SSDI and employment are key, obtaining these resources does not always enable a person to pay for their own stable housing. SSI payments are around \$720/month which would not allow a Chicago resident to obtain a home without a rental subsidy. Likewise, nowhere in Illinois can you work a 40-hour a week minimum wage job and afford the fair market rent on a two-bedroom apartment. This does not mean that these resources should not be pursued and employment training and assistance provided, when a person is able to pay for a portion of their rent, this lowers the amount of rental subsidy needed and increases the number of people who are able to be supported with the same amount of funding; having your own resources and being able to work are also very therapeutic and of benefit to all who wish to be truly integrated into society. My concern is that the idea of temporary rental assistance or transitional rental assistance could be setting the system and the person up for failure. The homeless service world has found that for most people, transitional housing is not a great option because there is nowhere to transition to; in the Division of Mental Health, we have numerous people who are considered to reside in transitional residential programming settings (many of which are actually individual units with on-site services), again with nowhere affordable to transition to. Without question, the state needs to develop a rental subsidy program for persons with disabilities with its own dedicated funding stream (the Section 811 award is a great place to start) but basing a rental subsidy on incentive payments that might be here today and gone tomorrow, is dangerous.

Pg. 46 Wrap-around services, targeted case management, step down services are ways you could think about flexible supports that surround a person in their domicile, assisting them to remain housed and healthy. These should be part of the long term support services package since they are proven to reduce costs and increase the health of people with disabilities.

Pg. 49 Expenditure Authority Waiver Requests: Perhaps the services listed above (Pg. 46) should be included in the HCBS expenditure authority waiver request?

Pg. 50 Is supportive housing a “designated state health program”? It fits the criteria of contributing directly to the ability of the Medicaid program to control costs, maintain beneficiaries in the least restrictive settings, and maintain beneficiary access to needed services.

Pg. 51 Certain specialized and crisis response mental health services managed by the Division of Mental Health – supportive housing would be a specialized response and it would also be available in the Division of Family and Community Services, Office of Adult Services and Basic Supports.

Pg. 59 Is there a reason that you couldn’t consider single-site supportive housing projects as Residential Habilitation?

Pg. 68 Very excited by the idea of including Supported Employment services in the 1115 Waiver application! (Why are these services considered medically necessary when housing isn’t? Housing has a much stronger tie to positive health outcomes.)

Pg. 69 Very excited by the idea of including Non-Medical Transportation services in the 1115 Waiver application! (Why are these services considered medically necessary when housing isn’t? Housing has a much stronger tie to positive health outcomes.)

Thank you for the opportunity to give you some initial reactions to the draft 1115 Waiver application. I am very excited by the possibilities and will assist in any way that I can.

Lore Baker